**To**

Public Health Clinic Services

925-313-6250***(phone)***

925-313-6029 ***(fax)***

\*\*\*Please attach all pertinent medical records and patient registration with current demographics.

If requesting feedback, please include phone number to call.

***Due to limited resources, all clients may not be served.***

PLACE REGISTRATION STICKER HERE



# Public Health Nurse Referral Form

(For Clinic Referrals only)

Date of Referral: \_\_\_\_\_\_

Provider: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Coordinator:\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_ Parent/Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**please attach patient registration sheet (face-sheet)**

**and pertinent clinic notes**

Demographic information **(if different than patient registration):** ­­­­­­­­­­­­­­­­

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language:□ English □ Spanish □ Other

**Reason for Referral:**

□ Postpartum at risk (lactation issues, teen, social issues) Child at risk/needs linkage to:

* Newborn at risk □ Specialty Care □ Developmental Services

(wt loss 8- 10%, SGA, medical issues, feeding issue, < 36wks gest) □ Mental Health □ School District

□ Perinatal Depression (mod/severe) □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief Description of the reason for referral:

**Disposition:**

□ Unable to contact/locate □ Assigned to PHN

□ Does not meet criteria for services □ Unable to provide services

Completed by: Phone: Program:

□ Feedback requested To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_